



POTTER'S WHEEL COUNSELING INFORMED CONSENT FORM



It is important for you, as a client of Potter's Wheel Counseling (the Counseling Center) to be fully informed about the therapy services you will be receiving. Your signature below indicates that you have received, read, and understand your rights and responsibilities under this agreement and agree to enter a therapy relationship with the Counseling Center upon the terms of this agreement.

The Process of Counseling

The Counseling Center will introduce you to a therapist who will work with you to identify presenting issues and develop a plan of care to assist you. Professional counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. Change is facilitated as the client and therapist establish a mutually respectful partnership.

The therapist will facilitate a process of communication and provide knowledge based on psychological growth and development. It is your obligation to identify personal goals towards which you desire to move and obstacles which may prevent that movement. The purpose of this process is to enable the client to move toward greater psychological health and satisfaction. While the process is effective for many people there are no guarantees of success.

Professional Disclosure Statement

The Counseling Center is a Christian based ministry to serve those who need assistance. We are comprised of a team of therapists who work from a Christian perspective and strive to integrate the truth of theology and psychology. We primarily utilize trauma resolution therapy to promote the healing process. We provide individual and group counseling. We are committed to respecting the values of each person and to give the client a safe place in which to seek growth. Your therapist will inform you of his/her specific plan of treatment for you. Because the Counseling Center is a specialized treatment facility, we focus primarily on trauma. If your presenting issue is not clearly based on trauma or you choose not to follow your therapist's treatment plan, you will be referred out to a different counselor that is more specialized in your specific area of need. If you are referred, a minimum of three other counselor's names and contact information will be provided.

Practical Issues

1. Licensure and Ethics

- a. The State of Georgia, through the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists, licenses mental health professionals. If your counselor is currently undergoing the process of licensure, she/he will be under the supervision of a Licensed Professional Counselor, as per the Composite Board requirements. If your counselor is not currently licensed, a separate form will be provided to you with their supervisor and director's name and number.

b. As Mental Health Professionals, we are committed to practice according to the ethics of our profession. We uphold the American Association of Christian Counselor Code of Ethics. Copies of our ethical code are available, if requested. Clients can contact the Composite Board with questions or to register complaints about any mental health professional. We ask that you contact the executive director of the Counseling Center (Michelle Allen at 678-755-3612) if you have a concern or complaint.

2. Confidentiality

a. As Mental Health Professionals, we are ethically and legally committed to the confidentiality of disclosures that clients make. Exceptions occur if:

- 1) a client is a danger to self or to others;
- 2) when there is a reason to suspect abuse or neglect of a child, an elderly person, or a disabled adult;
- 3) when the judicial system orders client records to be made available.

b. In keeping with accepted professional practices, sometimes we request client's permission to consult with other professionals about the client's situation. A release of information form is provided for the client to indicate willingness to grant that permission in writing. By signing this form, the client is authorizing his/her therapist to discuss case information as needed with the Counseling Center staff, therapists, and clinical supervisor for oversight and consultation. As a counseling center we operate under the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

c. In order to rule out any physiological reason underlying your current symptoms, your counselor would like to consult with your primary care physician. The purpose of such consultation is to determine if there may be a medical condition or medication that may be causing or contributing to the symptoms. The client/parent/legal guardian may also choose to waive such consultation. The clinician may provide treatment or evaluation until such time that the medical consultation is obtained or waived.

I accept the consultation _____ **(initial)** or I waive the consultation _____ **(initial)**

3. Fees

a. The Counseling Center does not currently accept insurance cases, but your individual counselor may be able to accept certain insurance plans. Please let your counselor know if you have insurance you would like to use. We also offer a sliding fee scale based upon financial need. Following the first session, upon request, the Staff will provide additional information on the sliding scale fee you qualify for. In order to qualify for a sliding scale, we require a copy of the first page of your most recent year's taxes for income verification. _____ **(initial)**

b. During the first session, family history and background information will be taken and an initial treatment approach will be decided. If the Counseling Center is not a good fit for the client's needs as the counselor determines them to be, appropriate referrals will be made and a second session will not be scheduled.

_____ **(initial)**

- c. In order to provide the best level of care, two assessments are given to each client at the beginning of treatment. These assessments are the DISC personality assessment and the SCL-90. These assessments are NOT optional. The cost for these assessments is \$50 and is not included in the regular session fee. The additional cost will be added to your regular second session fee and is due at the time of service. Additional DISC assessments are available upon request at a fee of \$25 each. This fee is NOT covered by your insurance. _____ **(initial)**
- d. The standard fee for an individual session is \$100. A standard session is 50-minutes in length. If additional time is needed, additional fees will be applied. A standard fee for a group session is \$40. A standard group session is 90 minutes. _____ **(initial)**
- e. If a therapist is subpoenaed to testify or submit records to the court, a fee will be assessed. For a written report a fee of \$150 will be charged. Because appearing in court requires cancelling a full day of clients, you will be billed for a full day for each day the counselor is required to report. The fee for the full day is \$1000. You will be billed \$50 per hour for preparation time. If the court appearance is more than 20 minutes away from the office at which you typically attend sessions, travel expense will also be billed. _____ **(initial)**
- f. If a therapist is contacted by phone by a client, after 10 minutes a fee will be applied comparable to prorated full standard session fees (at the rate of \$25 per 15 minutes). The client will be responsible for these charges, as they can not be billed to insurance. _____ **(initial)**
- g. Full payment (or insurance co-payment) is expected at the time of the service. You may pay with cash, check or credit card. A \$30 charge will be assessed for returned checks. Clients that have not paid for two sessions will be unable to schedule a third session until their account is paid in full. You are responsible for any balance not paid by your insurance. _____ **(initial)**
- h. If a client does not show up for an appointment or provide at least 24 hours notice of cancelling the appointment, a \$50 charge will be assessed for the first occurrence. For the second occurrence, a full standard session fee (\$100 for individual or \$40 for group) will be applied regardless of your negotiated fee. Exceptions may be warranted in the event of an emergency. _____ **(initial)**

4. Client Responsibility

- a. In working to achieve the potential benefits of therapy, it may require that the client make firm efforts to change. This may involve experiencing significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings of fear, anger, depression, frustration, and the like. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort, as well as relationship changes that may not be originally intended.

5. Record Keeping

- a. Clients will have a file created in his, her, or their name(s). The purpose of that file is to help the therapist remember relevant information and to carry out his/her responsibilities effectively and efficiently. Files will be maintained for ten years

after termination of the counseling relationship at which time the file will be shredded.

6. Contact with your Counselor

- a. If a client is experiencing a life-threatening emergency, they need to call 911 rather than contacting their counselor or the office staff.
- b. In all other situations, clients are requested to contact their counselor by calling their personal number or the office number. You may need to leave a message. All messages will be returned by phone or email by the end of the next business day.
- c. Clients who need to cancel appointments are requested to do so at least 24 hours in advance. This can be done by calling the main office number or your counselor's personal number.
- d. If for some reason, your therapist must cancel an appointment, he or she will call you at the number you have provided and, if you are not there, will leave a message stating, "This is [your therapist's name] calling for [your name] and I will be unable to keep our appointment today." Every attempt will be made to provide at least 24 hours notice of the cancellation. If you do not want us to contact you in this matter, please notify us so that we can discuss any alternative arrangements. _____ **(initial)**

I have read the information above and choose to enter into a therapy relationship under the circumstances described.

_____	_____	_____
Client or Authorized Representative	Date	Relationship to the Client
_____	_____	
Therapist	Date	